STATE OF ALASKA

AMENDMENT TO PROFESSIONAL SERVICES CONTRACT

1. Agency Contract Number	060706
2. ASPS Number	2007-0600-6640
3. Optional Renewal? ☐ Yes ☒ No	Years remaining____
4. Financial Coding	
5. Agency Assigned Encumbrance Number	0682242
6 Amendment Number	Nine (9)

This agreement is between the State of Alaska,

7 Department of Health and Social Services

Health and Social Services/ Health Care Services hereafter the State, and

8 Contractor

Xerox State Healthcare, LLC hereafter the Contractor

Mailing Address	Street or P.O. Box	City	State	ZIP Code
9040 Roswell Road, Suite 700		Atlanta	Georgia	30350

9 Original period of performance	10. Amended period of performance
FROM: October 1, 2007 TO: September 30, 2017	FROM: October 1, 2007 TO: September 30, 2017

11 Previous amount of contract to date	12. Amount of this amendment:	13. This amended contract shall not exceed a total of:
$ 146,274,042.31	$7,533,344.50	$153,807,386.81

14. In accordance with the provisions of the above referenced contract, the parties to that contract agree that the services to be performed by the contractor under the contract are amended as follows: All other terms and conditions of the contract remain in effect.

This amendment is to amend MMIS Operations appendix F and G adding the additional cost for SURS, SMAC, and Edifecs. Approval or continuation of the Operations Phase II is contingent upon CMS funding approval.

In full consideration of the Contractor's performance under and including this amendment, the State shall pay the Contractor a new total not to exceed $153,807,386.81

IN WITNESS WHEREOF the parties hereto have executed this amendment.

NOTICE! This amendment has no effect until signed by the head of the contracting agency, project director and head contracting agency or designee.

15. CONTRACTOR		17. CERTIFICATION:
Name of Firm: Xerox State Healthcare, LLC		I certify that the facts herein and on supporting documents are correct, that this voucher constitutes a legal charge agnist funds and appropriations cited, that sufficient funds are encumbered to pay this obligation, or that there is a sufficient balance in the appropriation cited to cover this obligation. I am aware that to knowingly make or allow false entries or alterations on a public record, or knowingly destroy, mutilate, suppress, conceal, remove or otherwise impair the verity, legibility or availability of a public record constitutes tampering with public records punishable under AS 11.56.815-.820. Other disciplinary action may be taken up to and including dismissal.
Signature of Authorized Representative	Date: 3/14/2014	
Typed or Printed Name of Authorized Representative: David Hamilton		
Title: Group President		
16. CONTRACTING AGENCY		Signature of Head Contracting Agency or Designee / Date: 3/17/14
Department/Division: Health & Social Services / Health Care Services		
Signature of Project Director	Date: 3-14-14	Typed or Printed Name of Authorizing Official: Darla Madden
Typed or Printed Name of Project Director: Craig Christenson		Title: Chief, Grants and Contracts
Title: Project Director		

APPENDIX F
PAYMENT PROVISIONS

Payments are based upon fixed rate outlined below. Phase III Operations performance period as indicated in the RFP will A-line with the original contract.

4j: Alaska State Maximum Allowable Costs Program (SMAC)

October 1, 2013 through December 1, 2013 monthly amount $20,445.83, not to exceed $61,337.49
January 1, 2014 through June 30, 2014; monthly amount $20,195.83, not to exceed $121,175.00

4k: Edifecs HIPAA TM License; $341,250.00 license fee first year, $358,313.00 (12/1/2015) second year, $376,229.00 (12/1/2016) third year, and $395,040.00 (12/1/2017) fourth year. This license fee is a pass through cost to the State. The State will provide 30 day notice if service is no longer required.

4l: Surveillance and Utilization Review (SURS) $122,500.00 per month

The contractor shall submit invoices and attachments to the address specified below no later than 30 days after the end of each month in which services were performed. Failure to include the required information on the invoice may cause an unavoidable delay to the payment process.

The contractor will submit invoices(s) for services performed in accordance with Appendix G. Each invoice must include:

- Contractor's name and contact information for questions regarding the invoice
- Contract number
- Date (s) of services performed
- Hours worked by individual and task category with the hourly rate

Contractor shall mail the original invoice and attachments:

Department of Health and Social Services
FMS/Grants and Contracts Support Team
Procurement Section - Attn: Lois Lemus
3601 C Street, Suite 578
Anchorage, AK 99503

Notwithstanding any other provision of this contract, it is understood and agreed that the State shall withhold payment at any time the contractor fails to perform work as required under Appendix F and /or G of this contract.

All terms, conditions, amendments, and conditions of the original contract remain in effect.

APPENDIX G
Scope of Work

Alaska State Maximum Allowable Costs Program (SMAC):

The contractor will perform the work as indicated in the SOU #S11-H0339-SMAC dated April 20, 2011 and attached as attachment #1 for reference, for the yearly fixed price maintenance.

Surveillance and Utilization Review (SURS):

Xerox Business Services, LLC ("Xerox") will provide the State of Alaska with a Surveillance and Utilization Review (SUR) Department responsible for the operation and leveraging the output of the ESUR solution developed under State of Alaska Contract #060706.

Xerox will provide adequate number of staff to complete the performance measure specified throughout the amendment. If DHCS finds the staff is not adequate, Xerox will need to add addition staff to comply.

Xerox will provide one full time SUR manager in Anchorage, Alaska

Xerox to provide experts as required to support the SURS team. To include but not limited to experts such as physicians, nurses, pharmacist, mental health specialist, statisticians and lawyers.

Xerox will conduct provider and member reviews for the purpose of identifying patterns of overutilization or misuse of Alaska Medical Assistance Program services. Reviews are conducted to determine the following:

- The services billed by the providers on claims documents were actually provided to Medicaid members who were eligible at the time that services were delivered.
- The services for which claims were submitted reconcile with patient medical chart record of the services rendered.
- The diagnosis recorded on the claim forms reconcile with medical charts.
- The provider records substantiate that the services were rendered on the dates for which the claims were submitted.
- The providers followed Medicaid rules and appropriately billed all third party payers.
- No duplicate billings and/or payments were made or received by the provider.
- The place of service code billed was accurate for the site at which the service was provided (inpatient hospital, office visit, etc.).
- Medicaid-eligible rendering providers were enrolled with Alaska Medicaid at the time of service.
- That the providers complied with their Alaska Medicaid Provider Agreement.

Xerox primary care program activities will include provider recruitment, Care Management Program (CMP) member identification, CMP processing activities, and appeal support.

Xerox will act as the State's agent in determining recoveries, negotiating terms with providers within state regulated guidelines, collecting recovery dollars and reconciling within the MMIS system.

The objective of these SUR activities is to provide tighter monitoring and control of Medicaid claims, resulting in a reduction of the total dollars related to claim payment through recovery of overpayment as identified through SUR activities, the reduction of provider errors and abuse through the education and the sentinel effect of the program, and clarification of billing procedures and policies.

SCOPE OF WORK

The Xerox SUR Department will be responsible for the following:

PROVIDER SUR ACTIVITIES

- Establish an Alaska baseline by performing a detailed analysis of provider claim activity. Xerox will select the review period to avoid timely filing requirements. The review period will cover at least 12 months.
- Maintain and modify algorithms as required to support program changes, policy changes and SURS focus areas.
- Maintain a formal documented SUR process and methodology. To be reviewed and verified on a quarterly basis by Xerox and any modifications will be reported to the State.
- Xerox SUR department will initiate 25 SUR generated provider cases, three (3) hospital cases and, if requested, accept up to five State referred cases on a quarterly basis. With the goal of closing 25 cases per quarter.
- At the State's discretion, 3 other providers/provider types may be substituted for the 3 hospital cases required each quarter. This may be done in instances when further investigation is needed on a particular provider type or when the hospitals in the exception reports are the same hospitals which were recently reviewed.
- On a quarterly basis, Xerox will generate reports identifying possible cases for review and recommend state action to be taken relative to the initial findings of the reviews. Case selection may be based on exception criteria, complaint activity, DMA request, problem focused analysis or a combination of these factors.
- The requirement for initiating a case is satisfied when Xerox SUR delivers DHCS a case initiation report.
- Once a case initiation report is delivered, DHCS will review it and instruct Xerox SUR on next actions. If DHCS determines medical records should be obtained from the provider, Xerox will conduct a desk level review of provider records upon receipt of the records from the provider. The findings from the review will be presented to DHCS in a desk level report.
- There is no specification for the number of cases Xerox SUR is required to close in a quarter or in a fiscal year. Xerox's ability to review records and create a desk level review is dependent on DHCS response time, approval of records requests, and the provider's timely response to a request for records.
- Xerox will prepare and provide all materials and supporting documentation necessary to perform desk level reviews of provider records, data extraction, data preparation, and preparation of all communications and other items necessary for the desk level reviews, as requested. Letters of notification and other letters regarding the review to individual providers will be produced by the contractor and subject to approval by the State.
- Xerox will provide a computer disk containing all accounting data when presenting desk level review findings to the State.
- Issues related to quality of care identified during desk level reviews will be reported to the State. Although assessment of quality of care is not the focus of this contract, the State recognizes that it has a responsibility to take note of any discrepancies that might indicate a quality of care issue. The documentation describing how potential quality of care issues were identified will be provided to the Division. The number of reviews will be determined by DHSS.
- Hold a minimal of four SUR provider meetings on a yearly basis. Provide a release at least six web based SUR education classes. All requirements per section 5.6.4 of the RFP apply.

MEMBER SUR ACTIVITIES

Xerox will aggressively review and identify Alaska Medical Assistance Program members for assignment into the Care Management Program. The number of reviews and program participant is not specified in the RFP.

- Profile member population and determine if a member is a candidate for the Care Management Program.
- Conduct reviews to determine actual mis-utilizers, including obtaining records from providers as necessary.
- If required, provider records will be obtained to assist in the review and assignment of members to the program.
- Xerox will be responsible for selecting CMP candidates (Division approval is not required).
- Actively market the Care Management Program to attract provider participation at a sufficient level to manage CMP members.
- After the 12-month CMP placement ends, the member will be re-evaluated to determine if continuance is appropriate. Should a member continue to qualify for lock-in, the member will be re-noticed to include fair hearing rights. Xerox must carry a minimum of 300 and a maximum 1,000 CMP. An active case is when they are eligible for Medicaid. Once ineligible the recipient must be taken of the list and be replaced with a new CMP member.
- Provide necessary support for member appeals.

Xerox Care Management Program process will include:

1) Profile member populations and determine if warning, monitoring or Primary Care placement applies.
2) Primary Care placement activities include:
    a. Generate notice to member (EIS system)
    b. Generate CMP Notice to Member (containing hearing rights notice)
    c. MMIS assignment to restricted provider
    d. Communications with member (information, physical location moves, etc)
    e. Communications with providers (including identifying members locked into that provider)
    f. Code EIS system to stop automatic coupons
    g. Generate CMP coupons for each member
3) After Primary Care placement ends, re-evaluate and determine if continuance is appropriate. Re-notice members as appropriate.
4) Provide necessary support for member appeals.

The services specified align to the RFP requirements which are very similar in nature to the legacy contract requirements.

MEMBER EXPLANATION OF MEDICAL BENEFIT (REOMBs) SUR ACTIVITIES

REOMB

- REOMB mailings and tracking will be accomplished through the MMIS system.
- The SUR department will review REOMB responses on a monthly basis.
- Responses indicating no service or inappropriate service was provided will be reviewed and appropriate action taken, including follow up with the member and provider. Cases will be opened and worked by the SUR team when appropriate.
- Returned REOMBS are tracked, reviewed, analyzed and, if substantiated, developed in to a complaint.
- Xerox will report all substantive responses to the State.

The system aspect and operation of sending the documentation is included as base RFP Requirement. The pursuit and follow up process is the delta as is represented in this item.

SUR COMPLAINT INVESTIGATION ACTIVITIES

Xerox will deploy, widely publish (web page, newsletter, publications, etc.) and provide ongoing support of an 800 line for reporting of fraud and abuse. Xerox will maintain activity tracking and produce monthly activity reports for this line. Xerox will conduct at least a preliminary investigation on all complaints, including returned Member Explanation of Medical Benefits (REOMB's) and, based on the results of the preliminary investigation, take appropriate action.

- Receive and document complaints from: s Xerox provided 1-800 number, members of the public; REOMB process; SUR web page; members; providers; or Divisions and Offices within the department.
- Perform initial investigation on all complaints received. The initial investigation will include a comprehensive review of information available in the MMIS system, EIS system, Provider File, contact logs, and complaint log. This information will be used to evaluate the competency of the complaint and the necessity of a more involved review. This requirement does require contact with providers or members. However, requesting pharmacy records may be necessary to complete an appropriate initial investigation where member abuse or misuse of the pharmacy program is concerned.
- Based on the results of the preliminary investigation, take appropriate action. Appropriate action may include: closing-unsubstantiated complaints, referring complaints to state division or agency, holding for Division action, or ongoing monitoring of complaint-related activities.
- At the completion of the initial investigation where the results indicate a significant concern, the complaint and related investigation will be brought to the attention of the appropriate Division of Health Care Services QA and/or Program Integrity Unit staff for consideration and possible action.
- In situations where the complaint or initial investigation gives rise to a concern over member or other personal physical harm, Xerox will immediately contact the appropriate Division of Health Care Services and/or Program Integrity Unit staff and provide all necessary information.

The RFP is silent on hotline and follow up activities related to suspected fraud or abuse of the program. The activities as currently provided will allow continuity of the program under contract #060706.

SUR REPORTING AND OTHER DEPARTMENTAL ACTIVITIES

- Xerox staff will research and become familiar with all pertinent Medicaid State and Federal Polices, regulations, and statutes.
- Maintain a case tracking system and provide monthly detailed reports to the State regarding case development and progress.
- When Xerox determines "that there is reason to believe" fraud has occurred, Xerox will immediately notify the State for referral to the Medicaid Fraud Control Unit.
- Xerox will prepare and submit an Administrative Report to the Division on a monthly basis. The report will explain the status of all desk level reviews and any provider results reported from provider self-audit activities. This report will include the status of each review and actions taken.
- Xerox will prepare and submit a Fiscal Year Annual Report to the Division. The report will summarize all activities for use in the Division's annual report to evaluate the cost effectiveness of SUR processes.
- Xerox will provide and update content for provider manuals regarding SUR policies and procedures on a regular basis.

SURS Invoices will have the following backup for approval:

Xerox will provide the following information as indicated as attachment #2 four pages. The Project Manager for SUR will continue to work with Xerox for requested backup for approval of invoices.

All terms and conditions of the original contract and all subsequent amendments remain in effect.

Attachment #1

Lynne Voss
Executive Account Manager
Alaska Medicaid
Government Healthcare
Solutions

1835 S. Bragaw Street - 200
Anchorage, Alaska 99508

Lynne.Voss@xerox.com
tel 907-644-6849
fax 907-644-8130

December 03, 2013

Lois Lemus
Procurement Specialist III
Department of Health & Social Services
PO Box 240249
Anchorage, AK 99503

Dear Ms. Lemus:

In May 2011, the State of Alaska signed a Statement of Understanding (SOU #S11-H0339) with Xerox, then Affiliated Computer Services, LLC, to design, develop and implement the changes for the State of Alaska State Maximum Allowable Cost (SMAC) Program. Yearly fixed price maintenance costs for the program were included in the SOU for the period of 07/01/2011 through 06/30/2014. Per the terms specified in the SOU, this annual cost has historically been divided into 12 payments and included in the monthly invoice for services rendered under contract #065776 (the "legacy contract").

Though the SOU did not specifically reference contract #065776, the monthly maintenance fee for the SMAC program was reflected in Appendix D (the payment schedule) for legacy contract Amendments 33, 37, 38 and 39 executed subsequent to the effective date of the SOU.

Please accept this letter as acknowledgement of Xerox's intent to continue to support SMAC maintenance activities as specified in the original SOU at the annual rates documented in the SOU through the specified end date of 06/30/2014. At your direction, we will continue to bill maintenance fees along with the monthly invoice for services now associated with contract #060706 (the "Enterprise contract").

Sincerely,

Lynne Voss

Lynne Voss

CC: Margaret Brodie, Division Director
Craig Steffen, Senior Vice President & Managing Director, GHS
Roger Linnell, Vice President, Sales

ACS

A xerox Company

Ross Becker

April 20, 2011

Ms Linda Walsh
Contract Administrator
Division of Health Care Services
4411 Business Park Blvd. Suite 46
Anchorage, AK 99503

RE: SOU # S11-H0339 – SMAC

Dear Ms. Walsh,

The attached Statement of Understanding contains the time, cost and effort for Affiliated Computer Services Inc., ("ACS") to have Magellan Medicaid Management ("MMA") design, develop and implement the changes for the State of Alaska State Maximum Allowable Costs (SMAC) Program.

Resources will be allocated on your approval of the attached Statement of Understanding. You will be billed for the actual development hours for this project using the rates stated on the attached SOU. Yearly maintenance costs are also included. The per annum cost will be divided into 12 payments and included in the monthly invoice, beginning with the month of implementation. For ease of administration and budgeting, we have set the monthly costs equal for all periods for the next four years.

If you, or any member of your staff, have any questions concerning this project, please do not hesitate to call.

Sincerely,

Ross Becker

Ross Becker
Executive Account Manager
Alaska MMIS

Attachments

CC: Jane Adkins
Tracy Jackson
Jacob Bender
Michelle Szafraniec

APPROVED FOR DESIGN
see enclosed annotation

Linda Walsh
DHCS Signature

5-18-11
Date

APPROVED FOR PAYMENT

DHSC Signature
DHCS
5/25/11
Date

State Maximum Allowable Costs (SMAC) Program

1.0 Overview

The Magellan Medicaid Administration Maximum Allowable Cost (MAC) program is developed to establish limits on certain generic drug products to ensure that state and federal governments are prudent purchasers of multi-source pharmaceuticals. Generic drug management is receiving more attention in recent years as generic dispensing rates (GDR) have steadily increased; a trend that will continue in the future.

Federal studies have pointed to higher reimbursement for generic drugs in the Medicaid program, than in the Part D program. Our Enhanced MAC program is designed to close this gap in reimbursement methodologies through the use of a proprietary algorithm that identifies MAC opportunities as they become available and match them with competitive pricing information.

Magellan Medicaid Administration has over nine years of experience providing MAC program services to state Medicaid programs and we currently support 10 public sector programs including Michigan, New York (and the New York EPIC Program), New Hampshire, Nevada, Kentucky, Florida, Virginia, Arizona (MCO), and South Carolina.

The Enhanced MAC program provides two major advantages over published price models that use AWP or WAC to determine their prices.

First, we process the First DataBank (FDB) file utilizing a proprietary algorithm to build the generic drug groupings for inclusion on the MAC file. This process ensures that we capture new MAC opportunities quickly while maximizing the total number of opportunities to limit reimbursement rates.

Second, we utilize wholesaler data to create acquisition based pricing rather than rely on published prices (e.g., WAC, AWP) resulting in significant

Magellan Medicaid Administration's Enhanced MAC program is an *acquisition-based model* that accounts for the unique requirements of Medicaid such as OBRA rebate requirements, federal and state reimbursement regulations, and the premise that Medicaid pricing must not compromise recipient access and should not discourage provider participation.

Magellan Medicaid Administration utilizes specific indicators on the FDB file to create the generic drug groupings selected for inclusion on the MAC list. Our process creates savings opportunities for over 2,200 generic drug groupings, approximately 400 more than a traditional

program. We then apply pricing information derived from a variety of sources to create competitive pricing points for each generic drug grouping

We also utilize information culled from the appeals process to identify shortages, pricing variances, and other drug availability issues to refine the list each month. These factors are built into our model and result in a fair and competitive price per unit, assigned to each generic drug grouping (usually a GSN).

The data output is carefully reviewed by skilled and experienced clinical and technical staff to ensure reliable and accurate pricing. The Magellan Medicaid Administration Enhanced MAC provides an algorithm that can evolve to accommodate changes in the regulatory environment, in the market place and changes gleaned from experience. This, combined with a system that allows for rapid implementation of these changes, provides a valuable tool in managing generic drug costs.

Appeals Process

Any competitive pricing program will have appeals from providers that could result in changed prices or changes to the model for that particular generic drug grouping. That said; most appeals stem from drug shortage and availability issues occurring with a particular wholesaler or chain of drug stores.

Providers may submit MAC-related inquiries directly to the MAC team by completing a *MAC Price Research Request* form and providing evidence of their pricing or difficulty obtaining the pharmaceutical at the set price (usually an invoice from their wholesaler). Once the MAC appeal request has been received, the MAC team will review available resources and make a determination based on current market availability and other product intelligence.

The MAC team will provide a written response indicating the outcome (whether approved or denied). If a MAC price adjustment is not warranted, the MAC team will provide suggested alternatives for product that is available below the current MAC rate within the response (whenever appropriate/possible). A monthly appeals log is maintained to document results and actions generated from inquiries received. The monthly appeals log will be made available to ACS and the State.

2.0 Requirements

Magellan Medicaid Administration will implement our innovative approach to MAC program management using an enhanced suite of database tools that enable Magellan Medicaid Administration to distill large amounts of data into manageable summaries and action steps. We offer a standard Enhanced MAC for our clients developed using these tools combined with a proprietary algorithm and pricing formula.

MMA will produce a full file at the onset of the program and weekly updates moving forward.

MAC prices will be applied based on date of service during adjudication. Historical price segments will be stored within the FirstRx™ claims adjudication system. Each price segment will maintain an effective and termination date. In the event there is an overlap, the most effective segment for the date of service is selected for adjudication.

2.1 Functionality

Enhanced MAC Pricing Algorithm is determined by using:

- First DataBank's drug file
  - FUL pricing
  - Specific drug data and indicators (e.g., rebate indicators, therapeutic equivalency ratings, others). MMA is committed to confidentiality and certifies that URAs are not used in our algorithm.
  - Package sizes
- Quarterly CMS rebate file
- Various proprietary pricing resources

2.1.1 Standard Enhanced MAC Process

- Determine list of generic drug grouping for inclusion in MAC list:
  - Use Magellan Medicaid Administration's proprietary algorithm to generate generic price groupings (usually at GSN level)
  - Apply exclusions based on drug availability/shortages
- Create MAC price points by generic drug grouping:
  - Use Magellan Medicaid Administration's proprietary formula
  - Apply pricing changes based on appeals
- Review updates manually and approve for loading into FirstRx™
  - Use of exception, disparity and threshold reports
- Generate standard reporting package showing add/change/deletes for the update.

2.2 *Reporting*

2.2.1 MAC Cost Avoidance Summary

- The cost avoidance attributed to the MAC program will be provided on a monthly basis. It is calculated as the difference between what would have been paid (in the absence of a MAC program) versus the actual cost paid (with MAC program in place).
  - ❒ Utilizing the state specific reimbursement algorithm
- Each claim that paid with a MAC price is re-priced without using the MAC price, using reimbursement algorithm in effect at the time of the claims adjudication (e.g. the lesser of WAC+X%, usual and customary, or FUL).
- These reports are provided in unlocked MS Excel format with the ability to assist the end user in the analysis of the data. These reports are designed to assist the state in identifying the cost drivers in their generic utilization and are provided in an easy to use, interactive format.

2.3 Add/Change/Delete File

Magellan Medicaid Administration will produce an Add/Change/Delete file upon each update to the MAC list:

- New GSN additions will appear on this report.
- Suspensions based on drug availability and shortages will appear on this report.
- Price changes will appear on this report.
- Deletions based on changing FDB indicators will appear on this report.

2.4 *Interface*

The Enhanced MAC will be provided weekly as an update file to the POS system.

2.5 Website

The Enhanced Mac list will be provided monthly for posting (as appropriate) on a website. This list will be provided in our standard format.

- Standard Add/Change/Delete report will also be provided on a weekly basis for website publication. MMA will provide the report to the State and ACS who will publish the report upon State approval.
- Full Enhanced MAC list will have the following layout:
  - Generic Drug Name/Strength/Dosage form/Route of Administration. GSN cannot be included on this report as it is proprietary value to FDB.
  - Enhanced MAC Price
  - Effective Date

3.0 Assumptions

- Magellan Medicaid Administration will use our proprietary algorithm and formulas to determine appropriate MAC generic drug groupings and pricing.
- Appeals are handled through Magellan Medicaid Administration MAC team utilizing the *MAC Price Research Request* form. Supporting invoices from providers may or may not be required.
- All appeals are between the Provider and Magellan Medicaid Administration; the State shall abide by appeal decisions. SCA regulations stipulate provider rights to second and third level State appeal. RB Lar
- MAC inquiries from the State or ACS are to be directed to the Magellan Medicaid Administration Account Manager who will collaborate with the MAC team for resolution.
- The Standard Enhanced MAC file (and update files) will be provided without customization.
- The Standard Enhanced MAC file will be provided for posting on the web without customization.
- Magellan Medicaid Administration will use a MMA defined phased-in approach for implementation. No new extracts, reports, or lists will be created in support of the Enhanced MAC program. Please click on the icons below to see examples of the reports.


SAMPLE_Weekly MAC.pdf


Sample_SMAC_report.xls

- All web postings will be submitted to ACS in PDF format.
- Support for education will require an additional fee outside of the agreements outlined in this Statement of Understanding document.

4.0 Constraints

- This SOU must be implemented before the New Payment Regulations work order. This SOU cannot be implemented any later than June 30, 2011.

5.0 Issues and Concerns

- This SOU must be implemented before the work order entitled New Payment Regulations, which has a drop-dead date of June 30, 2011.

6.0 Scope of Work

- Enhanced MAC file will be generated weekly using our proprietary pricing algorithm
- Enhanced MAC file will be loaded weekly into FirstRx™.
- Weekly updates will be available with the Add/Change/Delete report.
- Provide the standard MAC Cost Avoidance report package. Work is as described in previous sections.
- Add new IVR message.
- This SOU is for implementation of our standard Enhanced MAC program.
- Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates

7.0 Test

Magellan Medicaid Administration will utilize our standard approach to testing to validate our applications to ensure all aspects of the system are adequately tested and that the system can be successfully implemented.

8.0 Operational Impact

Since the state of Alaska has not utilized a MAC program in the past, it is anticipated that this may cause an increase in provider complaints and appeals. To help mitigate the impact, Magellan Medicaid Administration will add a new message to the IVR with options for information on the Enhanced MAC program

9.0 Response to State Comments and Questions

On April14, 2011, Magellan Medicaid Administration received comments and questions from the State of Alaska. The purpose of this section is to address those questions and comments which could not be adequately clarified above. At the State's request a meeting can be scheduled to further address these issues.

Comment 1- from Kristin Delfino, p.3, Section 1.0:

This is the 1st level of an appeal process.

Magellan Medicaid Administration Response:

The appeal process described in Section 1.0 is our standard process that we will implement for the State of Alaska on June 29, 2011. Making changes at this time based on a second /third appeal will create an Alaska specific list and program which may require additional staff and reevaluation of the June 29 implementation schedule. It is our position that we would like to accommodate the State's needs, but may have to engage in further analysis to understand the complete impact.

Comment from Kristin Delfino p.6, Section 3.0:

Alaska State regulations require that we allow for a second and third level of appeal.

Magellan Medicaid Administration Response:

We are committed to legislative compliance. As in Comment 1 response, we may need to discuss to understand the State's specific needs and whether or not there are options to explore that would not impact the June 29 delivery date.

MMA suggests that all level one appeals be handled by the MMA MAC Team as described in this SOU. Level 2 and 3 appeals will be managed and decided by the state and any changes to prices that may result be added to FirstRx as an additional price type. This price type would be the responsibility of the state to maintain (in collaboration with MMA Plan Administration for coding). It should be noted that savings resulting from this special price type would not be included in the cost avoidance report.

capat to 9R the WAC or Ful must cy :t w/in FR

Comment fr. Linda Walsh p.9, Section 6.0:

Add additional scope of work item for developing and providing reports to State to identify drugs on file in First Rx that have no WAC or FUL. This needs to occur at project onset so that SMAC's can be developed for these drugs. After "go live", this needs to occur weekly. Refer to State discussion with Magellan on 4/13/2011 8 a.m. AK time.)

Magellan Medicaid Administration Response:

The Scope of Work outlined is for our standard Enhanced MAC product and the State request requires creating unique MAC prices for State identified generic drug groupings that are not included in our standard file. Further discussion is needed to completely understand the State's business needs in full.

In order to not impact the implementation proposed for June 29th or cost of this solution, MMA suggests that the State deny the claim based on the following:

1) Provides incentive to manufacturer to submit WAC;
2) These drugs are not relevant to MAC pricing according to the standard MMA model;
3) Precedent. The States of MI,and MO along with many commercial plans operate in this manner.

Project Timeline

Delays in receiving the signature approval would impact the timeline shown below.

Project Timeline		
Due Date	**Task**	**Owner**
04/13/11	Present SOU to ACS	Magellan Medicaid Administration
4/14/11	Present SOU to SOA	ACS
4/21/11	Present revised SOU to SOA	ACS
4/25/11	Present signed SOU to ACS	State of Alaska
04/25/11	Present signed SOU to Magellan Medicaid Administration	ACS
05/02/11	Environment Setup and Configuration	Magellan Medicaid Administration
05/23/11	MMA begins testing	Magellan Medicaid Administration
06/15/11	Deliver Testing to SOA	Magellan Medicaid Administration
06/29/11	Enhanced MAC Go Live	Magellan Medicaid Administration

ESTIMATED RESOURCE REQUIREMENTS AND COSTS:

Resource Type	Estimated Hours	Rate	Charges
IT Charges:			
MMIS IT Resources			
Project Manager	20	$202.86	$4,057.20
FirstRx™ Resources			
One Time Implementation	150	$126.06	$18,909.00
Subtotal	170		$22,966.20
Total Estimated Charges for Implementation	**170**		**$22,966.20**
Yearly Fixed Price Maintenance Costs:			
Year #1, period of 07/01/2011-12/31/2011			$121,175
Fixed cost per year #2, period of 01/01/2012 – 12/31/2012			$245,350
Fixed cost per year #3, period of 01/01/2013 – 12/31/2013			$245,350
Fixed cost partial year #4, period of 01/01/2014 – 6/30/2014			$121,175

Prepared by: Tracy Jackson Date Prepared: April 21, 2011

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY (90) DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF AFFILIATED COMPUTER SERVICES, INC., A XEROX COMPANY.

Attachment #2

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Recipient Services

How many fair hearing requests were received	
How many recipients inquires received	
How many walk-ins in the month	
How many calls received	
Breakdown of types of calls received from recipients	Attach. 1
Number of recipient reimbursement requests received	

CTI Report by Date Range

Category	Type	Item
Recipient Services	CAMA	Covered Services
		Item Total
	Claim	Air Ambulance/Ground Ambulance
		Dental
		Institutional (IP, OP, RPTC, LTC)
		Lab
Recipient Services	Claim	Mental Health
		Other
		Professional
		Vision
		Item Total
	Fair Hearing	Other
		PCA Services
		Request
		Status
		Item Total
	Hot Topics	Abortion
		Item Total
	Other	Hang Up
		Wrong Number
		Item Total
	Prior Authorization	Dental
		DME
		Hotel/Meals
		Other
		PA Denied
		Transportation
		Item Total
	Provider Lists	Dentist In-State
		DME/In State
		Hospital/Out of State
		Hotel/In State
		Hotel/Out of State
		Orthadontia
		Other
		Pharmacy/ Out of State
		Professional/ In State
		Professional/ Out of State
		Taxi/In State
		Taxi/Out of State
		Vision/In State
		Vision/Out of State
		Item Total
	Recipient Education	Chiropractor
		Co-Pay
		Dental
		DME
		Medicaid Coupon
		Orthodontia
		Other
		Out of State Services
		Pharmacy
		Prior Authorization

		Professional
		TPL Update
		Transportation
		Vision
		Item Total
	Recipient Eligibility	Other
		Recipient Eligibility Verified
		Item Total
	Recipient Handbook	Handbook Sent
		Item Total
	Recipient Referral	DBH
		DPA Referral
		DSDS
		EPSDT Travel
		ET Contact Number
Recipient Services	Recipient Referral	HCM
		Medicare HMS
		Other
		PCG
		State Travel Office
		WIC
		Item Total
	TPL	MMIS vs EIS Updates
		Other
		Terminated
		Item Total
	Transfer Call	Care Management
		Enrollment
		Fair Hearing Rep
		Front Desk
		Manager
		Prior Authorization
		Provider Field Reps
		Provider Inquiry
		RSR
		SURS
		Item Total
	Category Total	

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SURS Services:

SUR activities during the month	•Monthly REOMB's printed and mailed, along with logging incoming mail •Recruited providers for 40 CMP placements in September 2013 •Ended September 2013 with 28 of 28 Case Initiations Delivered for 1st Qtr State FY14 •Ended September 2013 with 0 of 5 (optional) State Requested Cases Selected for 1st Qtr FY13 •Held two joint Xerox/HCS work sessions, reviewed control files, case status updates •Xerox is providing ongoing support and testimony for at least 5 active Fair Hearings as of 8/31/13 •Xerox is providing ongoing support and documentation to the AG's office in support of a legal challenge to CMP by the Disability Law Center •Xerox hosted EFAD training, 32 classroom hours for Xerox, HCS, DBH and SDS
Control file activities including files updated	CMP Control Files: •09/18/2013 XRX: ER Superutilizer •09/20/2013 ER Superutilizer (ER Only) Provider SUR Control Files: •09/11/2013 TOC 89 Hotel w/o Rest FY14:05
Provide documentation of provider cases that were initiated, in process or completed	• 9/11/2013 Selected HM6176 Parkwood Inn Corp • 9/11/2013 Selected HO0004 University Lakes Springhill Suites • 9/11/2013 Selected HM3279 Nullaqvik Hotel • 9/23/2013 Delivered Case InitiationPC00179 Pauline Aguilar • 9/23/2013 Delivered Case Initiation PC00544 Estela Marin • 9/23/2013 Delivered Case Initiation PC00853 Curtis McCubbins • 9/23/2013 Delivered Case Initiation PC02806 Renne Champagne • 9/23/2013 Delivered Case Initiation PC02840 Kevin Yong K Song • 9/23/2013 Delivered Case Initiation PC00308 Heather A Lee • 9/23/2013 Delivered Case Initiation PC01853 Ianka Petkova • 9/23/2013 Delivered Case Initiation PC03484 Rosemary Renner • 9/23/2013 Delivered Case Initiation PC01747 Her K Xiong • 9/23/2013 Delivered Case Initiation PC03358 Olinda D Thapa • 9/23/2013 Delivered Case Initiation PC03640 Michael Reale • 9/23/2013 Delivered Case Initiation PC04125 Regina Morse • 9/23/2013 Delivered Case Initiation PC02212 Kittie Plank • 9/23/2013 Delivered Case Initiation PC03292 Connie Roehl • 9/23/2013 Delivered Case Initiation PC01786 Darilyn Yeager • 9/23/2013 Delivered Case Initiation PC02666 Lucky Phothisane • 9/26/2013 Case Initiation Delivered MD27262 Rebecca White • 9/26/2013 Case Initiation Delivered MD05232 John Bursell • 9/26/2013 Case Initiation Delivered MD53872 Gordon Bozarth • 9/26/2013 Case Initiation Delivered HO3429 Best Western Golden Lion • 9/26/2013 Case Initiation Delivered HM0308 Chief Andrew Isaac Health Center • 9/26/2013 Case Initiation Delivered HO4496 Kanakanak Hospital Quarters • 9/26/2013 Case Initiation Delivered HO1129 Shelikof Lodge • 9/26/2013 Case Initiation Delivered HO1966 Plaza Inn • 9/26/2013 Case Initiation Delivered HO0014 AKHAPPYTIME LLC • 9/26/2013 Case Initiation Delivered HM6176 Parkwood Inn Corp • 9/26/2013 Case Initiation Delivered HO0004 University Lakes Springhill Suites • 9/26/2013 Case Initiation Delivered HM3279 Nullagvik Hotel
Number of SUR provider trainings, date, location, and number of participants	9/10/2013 Barrow Recipient Eligibility 15 attendees 9/17/2013 Webex, Intro to Medicad, 8 attendees, Recip elig 7 attendees 9/24/2013 Copper Center Recipient Eligibility 3 attendees
How many Case Management Program placements were completed with an estimated cost savings of $ per month	**40 placements** with an estimated cost savings **$1,649.82** per recipient per month, **$65,992.80** total monthly savings.
Number of recepient lock-in cases reviewed	**39** Phase 1 reviews **42** Phase 2 reviews
Number of recipients added to the lock-in program	40 Recipients notified on **September 30, 2013** for CMP (lock-in)
Number of complaints received and provide type of complaint	1 Total complaints received in **September 2013**, break down below
0	Access to Care
0	B - Billing Issue
0	B - Billing patient for covered services
1	C - QA: Inadequate care
0	C - QA: Other
0	E - Alias name overuse
0	R - Rx other, overuse

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")
BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement is between the State of Alaska, Department of Health and Social Services ("Covered Entity" or "CE") and Xerox State Healthcare, LLC ("Business Associate" or "BA").

RECITALS

Whereas,

A. CE wishes to disclose certain information to BA, some of which may constitute Protected Health Information ("PHI");

B. It is the goal of CE and BA to protect the privacy and provide for the security of PHI owned by CE that is disclosed to BA or accessed, received, stored, maintained, modified or retained by BA in compliance with HIPAA (42 U.S.C. 1320d – 3120d-8) and its implementing regulations at 45 C.F.R. 160 and 45 C.F.R. 164 (the "Privacy and Security Rule"), the Health Information Technology for Economic and Clinical Health Act of 2009 (P.L. 111-5) (the "HITECH Act"), and with other applicable laws;

C. The purpose and goal of the HIPAA Business Associate Agreement ("BAA") is to satisfy certain standards and requirements of HIPAA, HITECH Act, and the Privacy and Security Rule, including but not limited to 45 C.F.R. 164.502(e) and 45 C.F.R. 164.504(e), as may be amended from time to time;

Therefore, in consideration of mutual promises below and the exchange of information pursuant to the BAA, CE and BA agree as follows:

1. Definitions.

   a. General: As used in this BAA, the terms "Protected Health Information," "Health Care Operations," and other capitalized terms have the same meaning given to those terms by HIPAA, the HITECH Act and the Privacy and Security Rule. In the event of any conflict between the mandatory provisions of HIPAA, the HITECH Act or the Privacy and Security Rule, and the provisions of this BAA, HIPAA, the HITECH Act or the Privacy and Security Rule shall control. Where the provisions of this BAA differ from those mandated by HIPAA, the HITECH Act or the Privacy and Security Rule but are nonetheless permitted by HIPAA, the HITECH Act or the Privacy and Security Rule, the provisions of the BAA shall control.

   b. Specific:

      1) Business Associate: "Business Associate" or "BA" shall generally have the same meaning as the term "business associate" at 45 C.F.R. 160.103.

2) Covered Entity: "Covered Entity" or "CE" shall have the same meaning as the term "covered entity" at 45 C.F.R. 160.103.

3) Privacy and Security Rule: "Privacy and Security Rule" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

2. Permitted Uses and Disclosures by Business Associate.

a. BA may only use or disclose PHI for the following purposes:

b. BA may use or disclose PHI as required by law.

c. BA agrees to make uses and disclosures and requests for PHI consistent with CE's minimum necessary policies and procedures.

d. BA may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by CE, except for the specific uses and disclosures set out below.

e. BA may disclose PHI for the proper management and administration of BA or to carry out the legal responsibilities of BA, provided the disclosures are required by law, or BA obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notified BA of any instances of which it is aware in which the confidentiality of the information has been breached.

f. BA may provide data aggregation services related to the health care operations of CE.

3. Obligations of Business Associate.

a. Permitted uses and disclosures: BA may only use and disclose PHI owned by the CE that it creates, receives, maintains, or transmits if the use or disclosure is in compliance with each applicable requirement of 45 C.F.R. 164.504(e) of the Privacy Rule or this BAA. The additional requirements of Subtitle D of the HITECH Act contained in Public Law 111-5 that relate to privacy and that are made applicable with respect to Covered Entities shall also be applicable to BA and are incorporated into this BAA.

To the extent that BA discloses CE's PHI to a subcontractor, BA must obtain, prior to making any such disclosure: (1) reasonable assurances from the subcontractor that it will agree to the same restrictions, conditions, and requirements that apply to the BA with respect to such information; and (2) an agreement from the subcontractor to notify BA of any Breach of confidentiality, or security incident, within two business days of when it becomes aware of such Breach or incident.

b. Safeguards: 45 C.F.R. 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards), and 164.316 (policies, procedures and documentation requirements) shall apply to BA in the same manner that such sections apply to CE, and shall be implemented in accordance with HIPAA, the HITECH Act, and the Privacy and Security Rule. The additional requirements of Title XIII of the HITECH Act contained in Public Law 111-5 that relate to security and that are made applicable to Covered Entities shall also apply to BA and are incorporated into this BAA.

Unless CE agrees in writing that this requirement is infeasible with respect to certain data, BA shall secure all paper and electronic PHI by encryption or destruction such that the PHI is rendered unusable, unreadable or indecipherable to unauthorized individuals; or secure paper, film and electronic PHI in a manner that is consistent with guidance issued by the Secretary of the United States Department of Health and Human Services specifying the technologies and methodologies that render PHI unusable, unreadable or indecipherable to unauthorized individuals, including the use of standards developed under Section 3002(b)(2)(B)(vi) of the Public Health Service Act, as added by Section 13101 of the HITECH Act contained in Public Law 111-5.

BA shall patch its operating system and all applications within two weeks of the release of any patch. BA shall keep its antivirus and antimalware installed and active. BA shall limit its use of administrative accounts for IT operations only.

c. Reporting Unauthorized Disclosures and Breaches: During the term of this BAA, BA shall notify CE within 24 hours of discovering a Breach of security; intrusion; or unauthorized acquisition, access, use or disclosure of CE's PHI in violation of any applicable federal or state law, including security incidents. BA shall identify for the CE the individuals whose unsecured PHI has been, or is reasonably believed to have been, Breached so that CE can comply with any notification requirements if necessary. BA shall also indicate whether the PHI subject to the Breach; intrusion; or unauthorized acquisition, access, use or disclosure was encrypted or destroyed at the time. BA shall take prompt corrective action to cure any deficiencies that result in Breaches of security; intrusion; or unauthorized acquisition, access, use, and disclosure. BA shall fulfill all breach notice requirements unless CE notifies BA that CE will take over the notice requirements. BA shall reimburse CE for all costs incurred by CE that are associated with any mitigation, investigation and notice of Breach CE undertakes or provides under HIPAA, HITECH Act, and the Privacy and Security Rule as a result of a Breach of CE's PHI caused by BA or BA's subcontractor or agent.

   If the unauthorized acquisition, access, use or disclosure of CE's PHI involves only Secured PHI, BA shall notify CE within 10 days of discovering the Breach but is not required to notify CE of the names of the individuals affected.

d. BA is not an agent of CE.

e. BA's Agents: If BA uses a subcontractor or agent to provide services under this BAA, and the subcontractor or agent creates, receives, maintains, or transmits CE's PHI, the subcontractor or agent shall sign an agreement with BA containing substantially the same provisions as this BAA and further identifying CE as a third-party beneficiary with rights of enforcement and indemnification from the subcontractor or agent in the event of any violation of the subcontractor or agent agreement. BA shall mitigate the effects of any violation of that agreement.

f. Availability of Information to CE: Within 15 days after the date of a written request by CE, BA shall provide any information necessary to fulfill CE's obligations to provide access to PHI under HIPAA, the HITECH Act, or the Privacy and Security Rule.

g. Accountability of Disclosures: If BA is required by HIPAA, the HITECH Act, or the Privacy or Security Rule to document a disclosure of PHI, BA shall make that documentation. If CE is required to document a disclosure of PHI made by BA, BA shall assist CE in documenting

disclosures of PHI made by BA so that CE may respond to a request for an accounting in accordance with HIPAA, the HITECH Act, and the Privacy and Security Rule. Accounting records shall include the date of the disclosure, the name and if known, the address of the recipient of the PHI, the name of the individual who is subject of the PHI, a brief description of the PHI disclosed and the purpose of the disclosure. Within 15 days of a written request by CE, BA shall make the accounting record available to CE.

h. Amendment of PHI: Within 30 days of a written request by CE or an individual, BA shall amend PHI maintained, transmitted, created or received by BA on behalf of CE as directed by CE or the individual when required by HIPAA, the HITECH Act or the Privacy and Security Rule, or take other measures as necessary to satisfy CE's obligations under 45 C.F.R. 164.526.

i. Internal Practices: BA shall make its internal practices, books and records relating to the use and disclosure of CE's PHI available to CE and all appropriate federal agencies to determine CE's and BA's compliance with HIPAA, the HITECH Act and the Privacy and Security Rule.

j. Risk Assessment: BA shall biennially conduct a thorough assessment of the potential risks to and vulnerabilities of the confidentiality, integrity, and availability of CE's PHI that BA receives, stores, transmits, or has access to, and shall provide CE with a written report detailing the results of the assessment within 60 days of completing it.

k. To the extent BA is to carry out one or more of CE's obligations under Subpart E of 45 C.F.R. Part 164, BA must comply with the requirements of that Subpart that apply to CE in the performance of such obligations.

l. Audits, Inspection and Enforcement: CE may, after providing reasonable notice to the BA, conduct an inspection of the facilities, systems, books, logs and records of BA that relate to BA's use of CE's PHI, including inspecting logs showing the creation, modification, viewing, and deleting of PHI at BA's level. Failure by CE to inspect does not waive any rights of the CE or relieve BA of its responsibility to comply with this BAA. CE's failure to detect or failure to require remediation does not constitute acceptance of any practice or waive any rights of CE to enforce this BAA.

Notwithstanding BA's obligation to report under paragraph 3.c of this BAA, BA shall provide a monthly report to CE detailing the unauthorized, or reasonable belief of unauthorized, acquisition, access, use, or disclosure of CE's PHI, including any unauthorized creation, modification, or destruction of PHI and unauthorized login attempts. BA shall include privileged and nonprivileged accounts in its audit and report, indicating the unique individual using the privileged account. BA shall also indicate whether CE's PHI subject to unauthorized activity was encrypted or destroyed at the time of the unauthorized activity.

BA shall provide a yearly report to CE that lists the names of all individuals with technical or physical access to CE's PHI and the scope of that access.

m. Restrictions and Confidential Communications: Within 10 business days of notice by CE of a restriction upon use or disclosure or request for confidential communications pursuant to 45 C.F.R.164.522, BA shall restrict the use or disclosure of an individual's PHI. BA may not respond directly to an individual's request to restrict the use or disclosure of PHI or to send all communication of PHI to an alternate address. BA shall refer such requests to the CE so that the

CE can coordinate and prepare a timely response to the requesting individual and provide direction to the BA.

n. Indemnification: BA shall indemnify and hold harmless CE for any civil or criminal monetary penalty imposed on CE or monetary settlement reached by CE for acts or omissions in violation of HIPAA, the HITECH Act, or the Privacy or Security Rule that are committed by BA, a member of its workforce, its agent, or its subcontractor.

4. Obligations of CE. CE will be responsible for using legally appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to BA under the BAA until the PHI is received by BA. CE will not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA, the HITECH Act or the Privacy and Security Rule if done by CE.

5. Termination.

   a. Breach: A breach of a material term of the BAA by BA that is not cured within a reasonable period of time will provide grounds for the immediate termination of the contract.

   b. Reasonable Steps to Cure: In accordance with 45 C.F.R. 164.504(e)(1)(ii), CE and BA agree that, if it knows of a pattern of activity or practice of the other party that constitutes a material breach or violation of the other party's obligation under the BAA, the nonbreaching party will take reasonable steps to get the breaching party to cure the breach or end the violation and, if the steps taken are unsuccessful, terminate the BAA if feasible, and if not feasible, report the problem to the Secretary of the U.S. Department of Health and Human Services.

   c. Effect of Termination: Upon termination of the contract, BA will, at the direction of the CE, either return or destroy all PHI received from CE or created, maintained, or transmitted on CE's behalf by BA in any form. Unless otherwise directed, BA is prohibited from retaining any copies of PHI received from CE or created, maintained, or transmitted by BA on behalf of CE. If destruction or return of PHI is not feasible, BA must continue to extend the protections of this BAA to PHI and limit the further use and disclosure of the PHI. The obligations in this BAA shall continue until all of the PHI provided by CE to BA is either destroyed or returned to CE.

6. Amendment. The parties acknowledge that state and federal laws relating to electronic data security and privacy are evolving, and that the parties may be required to further amend this BAA to ensure compliance with applicable changes in law. Upon receipt of a notification from CE that an applicable change in law affecting this BAA has occurred, BA will promptly agree to enter into negotiations with CE to amend this BAA to ensure compliance with changes in law.

7. Ownership of PHI. For purposes of this BAA, CE owns the data that contains the PHI it transmits to BA or that BA receives, creates, maintains or transmits on behalf of CE.

8. Litigation Assistance. Except when it would constitute a direct conflict of interest for BA, BA will make itself available to assist CE in any administrative or judicial proceeding by testifying as witness as to an alleged violation of HIPAA, the HITECH Act, the Privacy or Security Rule, or other law relating to security or privacy.

9. Regulatory References. Any reference in this BAA to federal or state law means the section that is in effect or as amended.

10. Interpretation. This BAA shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy and Security Rule and applicable state and federal laws. The parties agree that any ambiguity in BAA will be resolved in favor of a meaning that permits the CE to comply with and be consistent with HIPAA, the HITECH Act, and the Privacy and Security Rule. The parties further agree that where this BAA conflicts with a contemporaneously executed confidentiality agreement between the parties, this BAA controls.

11. No Private Right of Action Created. This BAA does not create any right of action or benefits for individuals whose PHI is disclosed in violation of HIPAA, the HITECH Act, the Privacy and Security Rule or other law relating to security or privacy.

In witness thereof, the parties hereto have duly executed this BAA as of the effective date.